

## Eligibility

A dentist eligible for Active membership who is a full-time educator as defined by the respective university/institution, in a predoctoral department or an advanced specialty education program in endodontics accredited by the ADA Commission on Dental Accreditation or an institution that has a reciprocal agreement with the Commission are eligible for this category.

## Personal ID #

(For AAE Office Use Only)

## Personal Information

_____		
First Name	Middle Initial	Last Name
_____		
Nickname (if preferred)		Date of Birth (month/day/year)
_____		
Degrees/Designations		
_____		
Email		
_____		
Phone		Cell Phone
_____		
Fax		Website
_____		

## Address

_____		
Street Address	Suite/Apt.	
_____		
City	State/Country	Zip/Postal Code
_____		

Select:      Male      Female      Prefer not to answer

Select Ethnicity (optional):

Black/African American	White/Caucasian	Asian
South Asian	Middle Eastern/North African	Hispanic/Latino
Native American/Alaskan Native	Native Hawaiian/Pacific Islander	
Other _____	Prefer not to answer	

## Application Processing Instructions

Ensure your application contains:

Written verification from your local (ADA component) or state dental society (ADA constituent), or the American Dental Association stating you are a member in good standing. If you do not reside in the United States, submit written verification of membership from your recognized endodontic specialty association or, if none, the equivalent national dental association of the country in which you currently reside. ADA membership is required for the first year of AAE membership.

## Professional Affiliations

Current ADA or Equivalent National Dental Association (if residing outside the U.S.)  
Membership Number

## Educator Membership Dues Schedule

The membership dues cycle is based on the AAE fiscal year (July 1 – June 30). All memberships include a subscription to the *Journal of Endodontics*.

### Full year of membership

Applications received  
May 1 – December 31

Membership Dues:

**\$485 U.S.D.**

One-Time Application Fee:

**\$50 U.S.D.**

**Total Amount Due: \$535 U.S.D.**

### Half year of membership

Applications received  
January 1 – May 1

Membership Dues:

**\$245 U.S.D.**

One-Time Application Fee:

**\$50 U.S.D.**

**Total Amount Due: \$295 U.S.D.**

U.S. Taxpayers Please Note: The tax law prohibits taxpayers from deducting the expenses incurred by engaging in lobbying, as defined in the law. The law requires associations to provide their members with a reasonable estimate of the non-deductible percent of their dues attributable to lobbying activities. For 2026, 1% of a member's AAE dues are allocated to lobbying activities. Dues payments and contributions are non deductible as charitable contributions for federal income tax purposes.

\* Reduced rate offered with membership renewal only.

## Current Teaching Appointment

Dental School _____								Current Appointment Start Date _____
Select Title:	Academic Dean	Assistant Dean	Clinical Dean	Dean Dental School	Department Chair	Faculty	Predoc Director	Program Director
Select Status:	Full-Time	Part-Time	Full-Time Volunteer	Part-Time Volunteer				

## Teaching Verification

A signature of your dean or administrative head is required to complete this application and to take advantage of the reduced fees of the Educator membership. Annual status verification will be required.

- "I hereby verify that \_\_\_\_\_ (name of applicant) is a full-time faculty member of \_\_\_\_\_ (name of institution)."
- Please state your school's criteria for classification as a full-time faculty member: \_\_\_\_\_
- Faculty member's time commitment per week: \_\_\_\_\_ Hours \_\_\_\_\_ Days

Signature _____	Title _____	Date _____
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## Education

Dental School _____	Country _____
Date Started _____	Graduation Date _____ Degree(s) _____
Advanced Specialty Education Program in Endodontics _____	
Date Started _____	Graduation Date _____ Degree(s) _____
Other Graduate Schools/Programs _____	
Date Started _____	Graduation Date _____ Degree(s) _____

## Military

Current Military Branch _____
Date Started _____ Expected End of Service Date _____

## Practice Setting

Please select one:

Private Practice (Solo)	Endodontic Group Practice
Multi-discipline Group Practice (Specialists and Generalists)	
Military/Government Practice	Dental School Faculty
Independent Contractor	Not Currently in Practice
Other _____	

## Payment

Check in U.S. funds

Check Number _____	Amount _____
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*Check must be clearly printed in U.S. dollars.*

Credit Card:	<input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> American Express <input type="checkbox"/> Discover
Card Holder's Name (print) _____	Amount _____
Card Number _____	Security Code _____ Expiration Date _____

I hereby apply for membership in the American Association of Endodontists and resolve to abide by the Association's Bylaws as well as the *Principles of Ethics and Code of Professional Conduct of the American Dental Association* if accepted into membership. If I have paid by credit card, my signature authorizes payment.

Signature _____	Date _____
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